HOUSE . . . . . No.

Message from His Excellency the Governor recommending legislation relative to improving the quality of health care and controlling costs by reforming health systems and payments. February 17, 2011.

The Commonwealth of Massachusetts

EXECUTIVE DEPARTMENT
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DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

February 17, 2011.

To the Honorable Senate and House of Representatives:

I am filing for your consideration a bill entitled, "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments." Through our collective efforts during the past several years, Massachusetts has become a national leader in health care reform. Today, we have an opportunity to expand that leadership by ensuring that health care is universally affordable.
The bill I am filing will lower health care costs for consumers while providing the health care industry both the incentives and the freedom to innovate and find lower cost ways to deliver better care.

This legislation will realize these goals by:

- Giving the Commissioner of the Division of Insurance authority to consider several new criteria when deciding whether or not to disapprove excessive health insurance premium increases;

- Encouraging the formation and use of integrated care organizations, comprised of groups of providers that work together to achieve improved health outcomes for patients at lower costs;

- Establishing benchmarks and timelines for the transition to "alternatives to fee for service" and the predominant use of integrated care organizations by 2015;

- Encouraging the use of payment methods (such as global payments, bundled payments, etc.) that will decrease total per capita expenditures on health care, and the rate of growth in expenditures for health care in the Commonwealth, and improve the efficiency, effectiveness and quality of health care delivery;

- Ensuring transparency and accuracy of payer and provider costs, provider payments, clinical outcomes, quality measures, and other information which is necessary to discern the value of health services;

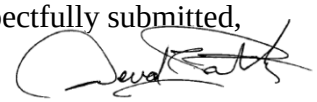
- Empowering the relevant state entities to monitor and address disparities in the health care market that contribute to high health care costs; and

- Discouraging the practice of defensive medicine and improving the quality of health care by requiring open communication between providers and patients during a "cooling off period" before litigation can commence and limiting the use of a physician's apology in litigation.

With the passage of the health care reform bill in 2006, the Commonwealth of Massachusetts became the first state in the nation to take on the challenge of ensuring access to health care for all its residents. This is the year we take on the challenge of ensuring that high quality care is also universally affordable.

I urge your prompt and favorable consideration of this legislation.

Respectfully submitted,



DEVAL L. PATRICK,
Governor.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven.

AN ACT IMPROVING THE QUALITY OF HEALTH CARE AND CONTROLLING COSTS BY REFORMING HEALTH SYSTEMS AND PAYMENTS.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is forthwith to improve the quality of health care and control costs by reforming health systems and payments, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health and convenience.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

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Finding and Purposes

SECTION 1. The general court finds that:

(a) The commonwealth leads the nation in the percentage of residents who have health insurance, with more than 98% covered. The rate of insurance coverage has increased for all income levels and among all racial and ethnic groups in the commonwealth. As of June 2010, more than 400,000 people in the commonwealth had insurance who had previously been uninsured before enactment of the 2006 health care reform act. Furthermore, the proportion of employers offering health insurance to their employees has increased to 76%, while the national average is 69%. While the commonwealth ranks first in the nation in providing access to its residents, the Commonwealth Fund ranks Massachusetts thirty-third on avoidable hospital use and costs. This ranking reflects the need to improve quality and coordination of care. In addition Medicare reimbursements per Massachusetts enrollee are among the highest in the nation reflecting the overall higher cost of health care compared to the rest of the nation.

(b) The rate of increase in health care costs has outpaced growth in the economy and threatens the financial health of individuals and businesses, while squeezing out other priorities for government spending. Left unchecked, per capita health care spending in the commonwealth is expected to continue to outpace the annual rise in the gross domestic product, with total health care spending reaching $123 billion by 2020.

(c) Many of the cost and quality problems in health care are either caused or exacerbated by the current fee-for-service payment system. Under most current health care payment arrangements physicians, hospitals, and other providers receive more revenue for delivering more services, not for delivering higher quality services or services that are more effective in improving an individual's health. Providers who keep individuals well or help them manage chronic medical problems effectively are not rewarded for those outcomes. In fact, providers are often penalized if visits to the doctor are avoided, tests or procedures are appropriately not scheduled and hospital beds are not filled. While many of the advances in medicine and the understanding of disease processes indicate that providers can act to prevent chronic diseases, help patients manage those diseases to avoid complications, and prevent adverse outcomes from occurring, achieving these outcomes requires providers to deliver care across many settings and to work as a team. Yet separate payments are made to physicians, hospitals and other health care providers involved in an individual's care. There are few incentives for providers to coordinate their services and many preventive and care coordination functions are not reimbursed or are poorly reimbursed.

(d) In addition there are wide variations in prices paid by insurers to providers for the same or similar services. There is a need for greater transparency about the rationale for these differences in payments in order to maintain access to the full continuum of health care services from primary care to quartenary care.

(e) Therefore, it is necessary to enact legislation to limit health care costs while improving health care services to residents of the commonwealth. This act achieves those goals by:

(i) Encouraging the formation of integrated care organizations, commonly referred to as accountable care organizations, comprised of connected or integrated groups of health care providers that achieve improved health outcomes and lower the costs of care.

(ii) Providing for payment methods that will decrease total per capita expenditures, and the rate of growth in expenditures for health care in the commonwealth, and improve the efficiency, effectiveness and quality of its health care delivery systems. Payments will move from predominant fee-for-service to global and other alternative payment methods for the provision of health care services. All public and private payers in the commonwealth will move to reimbursements that are based on the quality rather than the volume of services, and employ comparable approaches to clinical risk adjustment and payment methodologies for comparable patient groups.

(iii) Ensuring transparency of payer and provider costs, provider payments, clinical outcomes, quality measures, and other information is necessary to discern the value of health services; and ensure such information is accurate, relevant and publicly available. All residents of the commonwealth must have the information they need to make informed choices among primary care clinicians, other providers and integrated systems.

(iv) Providing a transition period for improving the delivery system and for adopting alternative payments. Upon passage of this act, the division of insurance will

have additional authority to take into account provider rate increases and provider rate disparities in considering whether premium increases are justified.

(v) Enacting strong safeguards for consumers to ensure continued access for all.

Powers of Attorney General

SECTION 2. Chapter 12 of the General Laws is hereby amended by inserting after section 11L the following section:-

Section 11M. The attorney general shall:

(a) monitor trends in the health care market during the reorganization of the health care system; including but not limited to trends in ACO size and composition, consolidation in the ACO and provider markets, payer contracting trends, impact on patient selection of provider and ACO, and other market effects of the transition from fee-for-service forms of payment.

(b) in consultation with the coordinating council, take appropriate action to prevent excess consolidation or collusion of providers or ACOs and to remedy these or other related anti-competitive dynamics in the health care market;

(c) provide assistance as needed to support efforts by the commonwealth to obtain exemptions or waivers from certain provisions of federal law including, from the federal office of the inspector general, a waiver of the provisions of, or expansion of the "safe harbors" provided for under 42 U.S.C. section 1320a-7b; and obtaining from the federal office of the inspector general a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to (e).

As used in this section, terms shall have the meanings assigned by section 1 of chapter 118I.

SECTION 3. Chapter 93A of the General Laws is hereby amended by adding the following section:

Section 115. A health care provider, as defined in section 1 of chapter 176O, shall not recoup or attempt to recoup amounts in excess of the amounts charged to carriers pursuant to section 5A of chapter 176O by increasing charges to other health benefit plans or other payers. The attorney general may adopt regulations enforcing this section, which shall include requirements for identifying and enforcing noncompliance and penalties for noncompliance.

SECTION 4. The attorney general shall analyze all state and federal laws and regulations that have any impact on the implementation of this act, including but not limited to state and federal antitrust provisions, and not later than April 1, 2012 or 180 days after enactment of the act, whichever is later, submit a report to the joint committee on health care financing and to the coordinating council established by chapter 118I of the General Laws. The report shall: (a) analyze the sufficiency of current state and federal antitrust law to provide adequate remedies and market intervention tools for appropriate protection of competitive markets and price regulation relative to the transition to accountable care organization and alternative payment methodologies for the delivery of health services in the commonwealth; (b) recommend any amendments to such laws to improve the adequacy of remedies and interventions available to protect markets against anti-competitive trends; and (c) make specific recommendations for any other statutory and

regulatory changes to create sufficient tools and authority to adequately protect the interests of consumers and purchasers in sustaining an open and competitive market for the purchase of health care services.

Health Information Technology Council

SECTION 5. Section 6D of chapter 40J of the General Laws is hereby amended by striking out subsection (b), as amended by section 97 of chapter 240 of the acts of 2010, and inserting in place thereof the following subsection:-

(b) There shall be a health information technology council within the corporation. The council shall advise the institute on the dissemination of health information technology across the commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.

The council shall consist of 18 members, as follows: 1 shall be the secretary of health and human services, who shall serve as the chair; 1 shall be the secretary of administration and finance or designee; 1 shall be the secretary of housing and economic development or designee; 1 shall be the director of the office of Medicaid or designee; 1 shall be the commissioner of public health; and 13 shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1 shall be an expert in law and health policy, and 1 shall be an expert in health information privacy and security; 1 shall be from an academic medical center; 1 shall be from a community hospital; 1 shall be from a community health center; 1 shall be from a long term care facility; 1 shall be from large physician group practice; 1 shall be from a small physician group practice; 1 shall represent health insurance carriers; and 3 additional members shall have experience or

expertise in health information technology. The council may consult with parties, public or private, that it considers desirable in exercising its duties under this section, including persons with expertise and experience the development and dissemination of electronic health records systems, and the implementation of electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointive members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

The members of the council shall be deemed to be directors for purposes of the fourth paragraph of section 3. Chapter 268A shall apply to all council members, except that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided, however, that such interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no member shall be deemed to have violated section 4 of said chapter 268A because of his receipt of his usual and regular compensation from his employer during

the time in which the member participates in the activities of the council.

Expansion of Medical Peer Review

SECTION 6. Section 1 of chapter 111 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out, in line 38, the words "one hundred and seventy-six G" and inserting in place thereof the following words:- 176G or within an accountable care organization certified by the division of health care finance and policy under chapter 118I.

Division of Health Care Resource Planning

SECTION 7. Section 25B of chapter 111 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word "minimum", in line 118, the following words:- ; or as further determined by the state health plan.

SECTION 8. The definition of "Substantial change in services" in said section 25B of said chapter 111, as so appearing, is hereby further amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- Any increase in bed capacity of more than 4 beds for any hospital licensed pursuant to section 51 shall constitute a substantial change in service. The department may further define substantial change in service in accordance with the state health plan.

SECTION 9. The sixth paragraph of section 25C of said chapter 111, as so appearing, is hereby further amended by adding the following sentence:- Any such determination by

the department shall be consistent with the state health plan issued by the health planning council pursuant to section 25L.

SECTION 10. Said chapter 111 is hereby further amended by inserting after section 25E the following section:-

Section 25E½. (a) There shall be in the department a division of health planning, in this section called the division. The division shall develop a state health plan every 2 years, amended more frequently as needed.

(b) There shall be in the department a health planning council consisting of the commissioner or designee, the director of the office of Medicaid or designee, the commissioner of health care finance and policy or designee, the secretary of health and human services or designee, the director of the division, and 3 members appointed by the governor, of whom at least 1 shall be a health economist; at least 1 shall have experience in health policy and planning, and at least 1 shall have experience in health care market planning and service line analysis. The health planning council shall advise the division and shall oversee and issue the state health plan developed by the division.

(c) The state health plan developed by the division shall include at least the following: (1) an inventory of current health care facilities that includes licensed beds, surgical capacity, numbers of technologies or equipment defined as innovative services or new technologies by the department, and all other services or supplies that are subject to determination of need, and (2) an assessment of the need for every such service or supply on a state-wide or regional basis including projections for such need for at least 5 years.

(d) The department shall issue guidelines, rules, or regulations consistent with the state health plan for making determinations of need.

Powers of Office of Patient Protection

SECTION 11. Paragraph (a) of section 217 of chapter 111 of the General Laws, as amended by section 8 of chapter 288 of the acts of 2010, is hereby further amended by adding the following clause:

(8) establish by regulation, after consulting the coordinating council established by chapter 118I, procedures and rules relating to appeals by consumers from accountable care organizations, and to conduct hearings and issue rulings on appeals brought by ACO consumers that are not otherwise properly heard through the consumer's payer or provider.

Powers of Division of Health Care Finance and Policy

SECTION 12. Chapter 118G of the General Laws is hereby amended by adding the following section:-

Section 42. As used in this section, terms shall have the meanings assigned by section 1 of chapter 118I. To facilitate a transition to a health care market where global and other alternative payment methodologies are the norm, the division shall monitor health care expenditures across the commonwealth and issue regulations consistent with the following:

(a) In consultation with the coordinating council, and pursuant to this chapter, the division shall collect, monitor, evaluate, and issue reports documenting and analyzing costs and payments for health care services in the commonwealth and shall further:

(1) Establish by regulation benchmarks for expanding the use of alternative payment methodologies and reducing the use of fee-for-service methodologies by payers and providers for the purpose of adopting alternative payment methods across the health care industry by the end of the year 2015 and for the purposes of lowering annual increases in total medical expenditures. Such benchmarks shall be consistent with the provisions of section 5A of chapter 176O and any regulations adopted under section 5A;

(2) Establish by regulation standards for alternative payment methodologies to be utilized in contracts between payers and ACOs and other providers consistent with the following requirements. All payers shall develop alternative payment methodologies consistent with regulations adopted by the division for the provision of integrated health care services to ACO patients and shall offer these methodologies to compensate ACOs. Payers may include additional payments for services provided to patients in addition to integrated health care services, which may include, but not be limited to, home health and chronic/rehabilitation services. The costs of integrated health care services shall be included in the cost base for the establishment of any alternative payment method to be used by payers. All contracts between payers and ACOs that contain a provision for shared savings between the provider and the payer shall contain a mechanism to return a percentage of the savings to the ACO members.

(3) Establish requirements for disclosure to the division of ACO costs, and of payments made by payers to ACOs;

(4) Require each payer to submit documentation to the division at least annually, certified by the payer's chief financial officer, which (i) demonstrates that the rates of payment under contracts with providers and ACOs in the upcoming year can be reasonably expected to result in spending not in excess of relevant cost containment benchmarks and growth rates established by the division, and (ii) shows the actual aggregate spending growth rate under the most recent contract year for all contracts in effect with providers and ACOs, the actual spending growth rate for all ACOs, and the actual spending growth rate for all other providers under contract with each payer; provided further that, the division may require additional reporting, as it deems necessary to properly monitor cost growth trends in the health care market;

(5) Monitor compliance by ACOs, providers, and payers with requirements established pursuant to this chapter and any implementing regulations promulgated by the division; achievement of benchmarks toward use of global and alternative payment methods by payers; cost growth trends in health care sector of the commonwealth's economy; and cost growth trends under global and alternative payment methodologies utilized by payers in the commonwealth;

(6) Hold hearings to determine appropriate cost growth and other benchmarks for the transition to the use of global and alternative payment methods, and payment limits for health care services;

(7) Waive any of its requirements to permit and support innovative demonstrations or pilot programs; provided that such waivers may only be

renewed if material savings or improvements in the delivery and quality of care can be documented, to the satisfaction of the division.

Notwithstanding any other provision of this section, the division shall encourage and assist providers with voluntary adoption of alternative payment methodologies as much as practicable relative to funding and resources available to the division under this chapter.

(b) The division shall promote transparency and information dissemination in the health care system, including pricing, purchasing, contracting, performance measurement and quality outcomes and accordingly shall:

(1) Collect from payers, providers, and ACOs data pertaining to health care costs, payments, competition among payers, providers and ACOs, and other matters relevant to its authority and duties under this section; provided that the division shall coordinate with other agencies of the commonwealth to obtain data already required to be reported by providers or payers to such agencies;

(2) Analyze such data to assess health care cost trends and the impact of the transition from fee-for-service payments to alternative payment methodologies; and

(3) Include its analysis in the annual report; but any data submitted pursuant to this subsection shall be classified as either (i) subject to release or publication or (ii) protected under a promise of confidentiality under subclause (g) of clause Twenty-sixth of section 7 of chapter 4.

(c) To support the transition to alternative payment methodologies, the division, in consultation with the coordinating council, shall:

(1) By March 31, 2012, document, categorize and publish all current payment arrangements in the commonwealth between payers and providers;

(2) Establish, facilitate and support transitional payment methodologies through pilot programs and other interim programs which have as their objective the modification of fee-for-service payment methods in a manner which creates incentives for higher quality care and more effective, efficient care delivery under alternative payment methods, including but not limited to the following:

a) Global payment with limits on the financial risk of ACOs, partial global payment and gainsharing with pay for performance; practice expense capitation with gainsharing, care management payments; bundled payments, episode-based payments, pay for performance; and shared savings;

b) Mechanisms to narrow the gap between payments to different providers for the same services;

c) Interim medical and social risk adjustment factors and measures;

d) Methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including but not limited to trauma units, burn units; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations; (iv) research; (v) care coordination and community based services provided by allied health professionals;

and (vi) the use and continued advancement of medical technology and pharmacology;

(3) Evaluate cost growth trends in any interim payment methodologies used during the transition to alternative payment methodologies, including pilot programs, for cost effectiveness and impact on quality of care and patient choice, and shall report and publish its findings to the coordinating council, the governor and the joint committee on health care financing annually, regarding which methodologies, based on analysis and comparison over time, are most effective in promoting efficient and coordinated care.

(d) With the input of expert advice, and in consultation with the coordinating council, the division shall evaluate and take measures to address ERISA restrictions and recommend potential incentives for employers who participate in self-funded plans to participate in alternative payment methods;

(e) The division shall study and evaluate best practices for the provision of high quality, efficient care in other states and nations for potential adoption into the alternative payment methodologies prescribed or monitored under this chapter.

(f) The division shall submit a written report annually to the coordinating council on all of its findings from its monitoring obligations, evaluations performed, and regulations promulgated pursuant to its obligations and authority under this chapter; provided, that such report shall include annual updates to all information required to be published in

section (c) (2) above; provided further, that such report shall also include a plan for achieving all milestones and benchmarks relating to the transition to alternative payment methodologies including adjustments for risk and other factors, and achievement of cost containment; and provided further, that the division may be required to submit additional or supplemental reports or analyses at the request of the coordinating council.

(g) The commissioner of the division or designee shall participate in all meetings of the coordinating council, and shall participate in making recommendations to other agencies represented on the coordinating council to promote the goals and purposes of this chapter. The commissioner shall adopt or otherwise implement all recommendations made by the coordinating council to the division.

Health Services System and Payment Reform, including Coordinating Council

SECTION 13. Sections 16J to 16L, inclusive, of chapter 6A of the General Laws are hereby repealed.

SECTION 14. The General Laws are hereby amended by inserting after chapter 118H the following chapter:-

CHAPTER 118I.

HEALTH SERVICES SYSTEM AND PAYMENT REFORM.

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Accountable care organization" or "ACO", an entity comprised of provider groups which operates as a single integrated organization that accepts at least shared

responsibility for the cost and primary responsibility for the quality of care delivered to a specific population of patients cared for by the groups' clinicians; which operates consistent with principles of a patient centered medical home and satisfies the other requirements of this chapter; which has a formal legal structure to receive and distribute savings; and which complies with any federal requirements applicable to ACOs, however named, which have been or may be enacted or adopted in law or regulation.

"ACO network provider", a provider that by contract or corporate structure participates in a specific ACO. Certain providers that are not primary care providers may be ACO network providers in more than one ACO, as set forth in regulation by the division.

"ACO patient", an individual who receives integrated health care services through an ACO, and for whom such services are paid by a payer to the ACO pursuant to the alternative payments set forth in this chapter.

"Alternative payment contract", an agreement between a payer and an ACO or other provider in which reimbursement available under the agreement is pursuant to an alternative payment methodology, as defined in this chapter, for services provided by an ACO or other provider. The contract shall include at least some performance based quality measures with associated financial rewards or penalties, or both.

"Alternative payment methodologies or methods", methods of payment that are not fee-for-service based and compensate ACOs and other providers for the provision of

health care services, including but not limited to shared savings arrangements, bundled payments, episode- based payments, and global payments, as defined in regulations adopted by the division of health care finance and policy. No payment based on the fee-for-service methodology shall be considered an alternative payment.

"Coordinating council", the health services system and payment reform coordinating council established by section 2.

"Division", the division of health care finance and policy.

"Fee-for-service", a payment mechanism in which all reimbursable health care activity is described and categorized into discreet and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient.

"Health benefit plan", as defined in section 1 of chapter 176G.

"Integrated health care services", health care services relating to the treatment of certain conditions, including but not limited to all conditions required to be covered under regulations of the commonwealth health insurance connector authority defining the core services and a broad range of medical benefits required for minimum creditable coverage and as adopted through regulation by the division in accordance with this chapter.

"Office of patient protection", the office within the department of public health established by section 217 of chapter 111.

"Patient centered medical home", any primary care practice which is organized in accordance with standards of the National Committee for Quality Assurance or as otherwise may be defined by regulation by the division, and which incorporates the principles set forth in the commonwealth's patient centered medical home initiative.

"Payer", any entity, other than an individual, that pays providers or ACOs for the provision of health care services. The term "payer" shall include both governmental and commercial entities, but excludes ERISA plans.

"Performance incentive payment" or "pay-for-performance", an amount paid to an ACO by a payer for achieving certain quality measures as defined in this chapter. Performance incentive payments shall comply with this chapter, regulations of the division of health care finance and policy, and the contract between an ACO and a payer.

"Performance penalty", an amount paid by an ACO to a payer or a reduction in the payments made by a payer to an ACO for failing to achieve certain quality measures as herein defined. Performance penalty provisions and their implementation shall comply with this chapter, any regulations of the division of health care finance and policy, and the contract between an ACO and a payer.

"Physician", a medical doctor licensed to practice medicine in the commonwealth.

"Provider" or "health care provider", a provider of medical or health services and any other person or organization, including an ACO, that furnishes, bills, or is paid for health care service delivery in the normal course of business.

"Purchaser", a private employer, individual, or government entity that buys health care services or insurance products on behalf of itself, its employees, or individuals enrolled in its programs.

"Quality measures", objective benchmarks established in accordance with nationally accepted performance metrics and as otherwise permitted under this chapter for assessing provider performance which may be the subject of a performance incentive payment or performance penalty, and which shall include the following: patient experience satisfaction and engagement measures, and health outcome measures and process compliance measures, and others as may be further detailed in regulations of the division.

Section 2. (a) There shall be an agency known as the health services system and payment reform coordinating council within, but not subject to the control of, the executive office of health and human services. The coordinating council shall establish a plan of action, a timeline, benchmarks, and standards to ensure and facilitate (i) the establishment of ACOs throughout the commonwealth by June 2015, (ii) the transition to utilization of alternative payment methods by all payers by June 2015, and (iii) the protection of quality, access and patient choice of primary care provider and accountable care organization for the residents of the commonwealth. The coordinating council shall

coordinate and make recommendations to agencies and entities represented on the council relating to pricing and reimbursement methods and quality measures to be utilized in contracts with payers of accountable care organizations, minimum criteria and other parameters for the formation of accountable care organizations and market parameters relevant to the development of fair, effective, efficient and sustainable global payment or other alternative payment methodologies in the purchase of health care services, including, at a minimum, integrated health care services for patients in the commonwealth by the target dates set by the coordinating council under the provisions of this chapter, and any other measures necessary to ensure that the growth rate of total medical expenditures in the commonwealth is reasonable and not excessive. The coordinating council shall be a public body for purposes of sections 18 to 25, inclusive, of chapter 30A.

(b) The coordinating council shall consist of the secretary of health and human services, the commissioner of mental health, the director of Medicaid, the commissioner of public health, the commissioner of health care finance and policy, the commissioner of insurance, the executive director of the commonwealth health insurance connector authority, the secretary of administration and finance or designee, the secretary of housing and economic development or designee, and the director of the Massachusetts health institute. The secretary of health and human services shall chair the coordinating council.

(c) The coordinating council shall consult regularly with an advisory committee, to be known as the health care innovation advisory committee, which shall consist of 18

members, 1 of whom shall be the attorney general or designee, 1 of whom shall be the inspector general or designee, 2 of whom shall be representatives of the acute care hospitals in the commonwealth appointed by the Massachusetts Hospital Association, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts; and 10 other members appointed by the governor with expertise and knowledge of health care systems and payments, 2 of whom shall be physicians certified in a specialty, 2 of whom shall be primary care physicians, 1 of whom shall be an advanced practice nurse with expertise in the patient centered medical home model of health care delivery, 1 of whom shall be a representative of behavioral health providers, 1 of whom shall be a representative of consumer health advocacy organizations, 1 of whom shall be a representative of a large, self-insured employer, 1 of whom shall be a representative of small employers, 1 of whom shall be a representative of organized labor representing health workers, 1 of whom shall be a representative of organized labor representing other workers, and 1 of whom shall be an expert in health policy.

(d) No member of the coordinating council shall be employed by, a consultant to, a member of the board of directors of, affiliated with, a representative of or have any fiduciary duty to a trade association of, an agent or broker of, or have an ownership interest, or financial interest in or fiduciary duty to, a carrier or other insurer, a health care provider, a health care facility or health clinic while serving on the coordinating council.

Section 3. (a) The division shall staff and support the coordinating council. The division shall facilitate the establishment of ACOs and ensure consistency and efficacy in the establishment and use of quality measures throughout the commonwealth to promote patient-centered, timely, safe care for individuals in the commonwealth. The division shall establish a plan of action, a timeline, benchmarks, and standards to ensure and facilitate (i) the establishment of accountable care organizations throughout the commonwealth by June 2015, and (ii) the protection of quality, access and patient choice of primary care provider and accountable care organization for the residents of the commonwealth. The division shall establish by regulation minimum criteria for the formation of accountable care organizations and parameters for quality measurements to be used in the evaluation of the performance of accountable care organizations.

(b) No staff member, employee, or other agent of the division shall be employed by, a consultant to, a member of the board of directors of, affiliated with, a representative of or have any fiduciary duty to a trade association of, an agent or broker of, or have an ownership interest, or financial interest in or fiduciary duty to, a carrier or other insurer, a health care provider, a health care facility or health clinic while employed by or otherwise providing services to the division.

Section 4. The coordinating council shall:

(a) monitor and assure inter-agency consistency and appropriate consumer protections with the implementation of health care payment and delivery reform by state and private entities in the commonwealth by coordinating actions among state agencies and ensuring, where appropriate, coordination with federal agencies and ensuring that regulations and

other forms of official guidance are issued by the appropriate agencies concerning: (i) the establishment of ACOs throughout the commonwealth and (ii) the transition to alternative payment methodologies for integrated and non-integrated delivery of health care services to be used as an alternative to fee-for-service payments.

(b) monitor and report on the health care expenditures across the commonwealth and recommend actions appropriate and necessary to agencies and entities represented on the coordinating council to contain the growth in health care costs incurred by all sectors of the health care economy, including the costs of payers, purchasers, plans, insurers, government and individuals.

(c) review and evaluate reports related to health services system and payment reform from the division of insurance, the division of health care finance and policy, the office for health care innovation, and the executive office of health and human services, and to publish these reports when final;

(d) ensure that all data collection, analysis, and other submission requirements established under this chapter are implemented in a manner which promotes administrative simplification, avoids duplication, and does not impose an undue burden on any entity or individual;

(e) make recommendations to agencies and entities represented on the coordinating council regarding all aspects of the transition to alternative payment methodologies, ACO

models of care, and controlling the cost of health care expenditures in the commonwealth; and

(f) prepare and submit reports to executive and legislative bodies identified in section [7] of this chapter relating to the achievement of benchmarks and other developments, evaluations, regulations and measures taken by the agencies and entities represented on the coordinating council in the transition to alternative payment methodologies, ACO models of care, and cost containment.

Section 5. The division shall:

(a) monitor and facilitate the reform of the health care delivery system by state and private entities in the commonwealth.

(b) adopt regulations and issue administrative bulletins and various other forms of official guidance concerning:

(1) the establishment of ACOs throughout the commonwealth and

(2) the establishment of standardized measures of quality to be used in the evaluation of the performance of ACOs.

(c) allow independent physician associations, physician-hospital organizations, and various forms of integrated health care organizations and entities to qualify as an ACO if they meet the criteria as set forth in this chapter and as established by the division under this section. The division shall encourage and assist providers with voluntary adoption of the ACO model of health care service delivery as much as practicable relative to funding and resources available to the division under this chapter.

(d) facilitate the establishment of ACOs throughout the commonwealth, provide by regulation for the certification or licensing of ACOs that meet the requirements of this chapter, and by June 1, 2012 establish by regulation minimum requirements for the formation of ACOs consistent with the following parameters and requirements:

(1) ACOs shall accept and share among their ACO network providers responsibility for the delivery, management, quality, and cost of the provision of at least all integrated health care services, as such terms are defined in section 3 of this chapter, to ACO patients, or other set of services as may be authorized and adopted by the division under this chapter;

(2) ACOs may be compensated through an alternative payment method for each ACO patient receiving services through the ACO, in accordance with this chapter and any regulations adopted under it by the division;

(3) ACOs must, at a minimum, have or obtain through contractual arrangement the following functional capacities:

a) Clinical service coordination, management, and delivery functions, including the ability to provide integrated health care services through its ACO provider network in accordance with the principles of a patient centered medical home; provided further, that ACOs shall be required to provide primary care coordination and referral services internally and not solely through contracts;

b) Population management functions, including health information technology and data analysis tools to provide at least: (i) patient-

specific encounter data; and (ii) management reports on aggregate data;

c) Financial management capabilities, including but not limited to the management of claims processing and payment functions for ACO network providers;

d) Contract management capabilities, including but not limited to network provider creation and management functions;

e) Quality measurement competence, including but not limited to the ability to measure and report performance relative to established measures of quality and performance under standardized quality measures;

f) Patient and provider communications functions; and

g) The ability to provide behavioral health services either internally within the ACO or by contractual arrangement.

(4) ACOs organizational structures must include consumer representations and ensure the ACO decision-making reflects the views of physicians, nurses, and other providers.

(e) Monitor the formation of ACOs in the commonwealth, and, in consultation with the coordinating council and the health care innovation advisory committee, establish any benchmarks deemed necessary or appropriate to facilitate the transition of health care providers and facilities into integrated care delivery systems;

(f) Establish safeguards against underutilization of services and protections against inappropriate denials of services or treatment in connection with utilization of any alternative payment method or transition to a global payment system;

(g) Establish safeguards against and penalties for inappropriate selection of low cost patients and avoidance of high cost patients by ACOs and ACO network providers, including but not limited to requiring that ACOs accept as ACO patients all individuals regardless of payer source or clinical profile;

(h) Adopt regulations requiring that primary care clinicians shall participate in only 1 ACO, except as otherwise specifically permitted by the division;

(i) Establish parameters to measure and ensure access by disabled and other individuals with chronic or complex medical conditions to appropriate specialty care;

(j) Establish reporting and disclosure requirements for ACOs and ACO network providers, including requirements for the disclosure by ACOs relative to performance on quality measures and other performance measures, and medical necessity and other criteria used in any alternative payment contract or agreement;

(k) Consistent with the regulations adopted under section 54 of chapter 288 of the acts of 2010, identify by regulation appropriate quality measures and parameters for quality measures, in consultation with the division of health care finance and policy and the department of public health, in accordance with the following: quality measures shall be designed so that they can be standard and uniform across all payers using alternative

payment methodologies, and shall include only evidence-based standards, standards adopted and utilized by the Centers for Medicare and Medicaid Services or standards generally accepted by one or more nationally-recognized quality metrics and standard setting organizations;

(l) In consultation with the department of public health, and the division of insurance, and consistent with quality measurements and standards established by nationally recognized professional organizations, establish parameters for clinical outcomes beyond the control of the clinician for which ACOs and ACO network providers shall not be financially responsible;

(m) Monitor ACO delivery systems paid under alternative payment methods to ensure that ACOs possess either internally or through contract arrangements the competencies necessary to operate as an effective ACO as determined by experts in the field and professional physician organizations, including but not limited to implementing a system of operational accountability to drive improved performance;

(n) Evaluate and provide guidance through regulations relative to consumer protections and any deficiencies of patient choice of provider that may arise in the transition from a fee-for-service system. The division shall monitor the movement of patients from and between ACOs, and shall establish parameters for out- of- ACO arrangements, as well as for patient provider choice and other consumer protections;

(o) Establish by regulation requirements for ACOs to address consumer grievances. Any individual or authorized representative of an individual who is aggrieved by restrictions on patient choice, or quality of care resulting from any final ACO action may request an external review by filing a request in writing with the office of patient protection of the department of public health within 45 days of the individual's receipt of written notice of the final adverse determination or receipt of care that fails to meet standard of care in that area or otherwise raises quality of care issues;

(p) Monitor and evaluate provider complaints, and may establish by regulations requirements for ACOs to address provider grievances;

(q) Monitor compliance by ACOs, providers, and payers with requirements established pursuant to this chapter and any implementing regulations promulgated by the division; barriers to entry by providers; excess consolidation of ACOs or other integrated services provider groups; and the trends in patient choice among providers and ACOs;

(r) Promote transparency and information dissemination in health care system, including pricing, purchasing, contracting, performance measurement and quality outcomes and accordingly shall:

(1) collect from payers, providers, and ACOs data pertaining to quality and other matters relevant to its authority and duties under this section; provided that the division shall coordinate with other agencies of the commonwealth to obtain data already required to be reported by providers or payers to such agencies;

(2) analyze such data to assess trends in performance, the impact of the transition ACO delivery systems, including changes in the workforce, trends in primary care physician capacity, and changes in health care provider practice operations, and including progress toward shared responsibility for the needed infrastructure, legal, and technical support for providers;

(3) include its analysis in its annual report; but any data submitted pursuant to this subsection shall be classified as either (i) subject to release or publication or (ii) protected under a promise of confidentiality under of subclause (g) of clause Twenty-sixth of section 7 of chapter 4;

(4) monitor provider and ACO acquisition and implementation of health information technology, and monitor compliance with standards established by the commonwealth's health information technology council; and

(5) establish by regulation parameters and rules to require obtaining patient consent for sharing information regarding patient care across all providers within a patient centered medical home and ACO.

(s) Consistent with the regulations adopted under section 54 of chapter 288 of the acts of 2010, advance the study and understanding of quality measures, by:

(1) Evaluating current standards and measurement of current best clinical practices;

(2) Establishing new quality measures that advance the level of clinical practice, patient satisfaction, and patient health outcomes, with particular emphasis on outcomes-based quality measures;

(t) In developing new knowledge and standards in the areas described in this section, study and evaluate the best practices for the provision of high quality, efficient care in other states and nations for potential adoption into the quality measures proscribed or monitored under this chapter;

(u) Provide guidance to ACOs and providers seeking to form an ACO, upon request or on its own initiative, on the potential implications of 42 U.S.C. section 1320a -7b and implementing regulations, and 42 U.S.C. section 1395nn(a) to (e) and implementing regulations in connection with such arrangements;

(v) Submit an annual written report to the coordinating council and the health care innovation advisory committee on all findings from its monitoring obligations, evaluations performed, and regulations adopted pursuant to its obligations and authority under this chapter. This report shall include a plan for achieving all milestones and benchmarks relating to the transition to the ACO model of care and establishment of standardized quality measures; and provided further, that the division may be required to submit additional or supplemental reports or analyses at the request of the coordinating council.

This section shall be construed in a manner consistent with any applicable federal laws or regulations governing ACOs, except as otherwise explicitly provided in this chapter or in the regulations adopted under it.

Section 6. (a) Self-funded plans may implement alternative payment methods in accordance with this chapter at their discretion and in accordance with all laws.

(b) To ensure participation by publicly funded health programs, the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority, and any other state funded insurance program shall, to the maximum extent feasible, implement alternative payment methodologies and use integrated care organizations and ACOs for the delivery of publicly funded health services, commencing no later than January 1, 2014.

Section 7. (a) The coordinating council shall prepare and submit annually a report setting forth all findings, evaluations, and regulations issued by each agency represented on the coordinating council and the plan and any recommendations made by the coordinating council to agencies represented on the coordinating council pertaining to the transition to alternative payment methodologies and ACO formation to the governor, president of the senate, the speaker of the house of representatives, the chairs of the joint committee on health care financing, and the chairs of the house and senate committees on ways and means. The council shall post the report on the public website of the executive office of health and human services.

(b) The annual reports to be filed pursuant to subsection (a) shall set forth specific benchmarks for the reduction of health care costs and the improvement of health care quality in the commonwealth, which shall include reduction in health care costs; and which shall include at least information and data regarding the following: the number and proportion of providers practicing without affiliation with or participation in an ACO; the

proportion of health care expenditures paid using a fee-for-service form of payment; the proportion of health care expenditures paid using global payment methodology; the proportion of health care expenditures paid using alternative payment methods; and the proportion of patients receiving care outside of an ACO; and the type of services and expenditures made through methods other than alternative payment methodologies; the type of services and expenditures made through alternative payment methodologies to providers that are not affiliated with an ACO; the proportion of health care expenditures paid pursuant to alternative payment methodologies to providers that are not affiliated with an ACO; the status of market competition for providers and ACOs; the barriers to entry, if any, for an ACO; the status of patient choice of provider and ACO; the cost growth trends for alternative payment method rates, in aggregate and for individual ACOs; the cost growth trends for fee-for-services expenditures in the commonwealth; ACO performance ratings; ACO quality ratings and trends and quality ratings and trends among providers not practicing as an affiliate or participant in an ACO.

(c) The coordinating council shall also submit bi-annual reports to the anti-trust and public protection divisions of the office of the attorney general, to provide the information and data, as determined necessary by the attorney general, to perform its oversight, monitoring, compliance and enforcement duties under section 11M of chapter 12.

Section 8. Interest on a legal judgment against an ACO shall be assessed at the federal funds rate in effect at the time the judgment is entered.

Powers of Division of Insurance

SECTION 15. Subsection (b) of section 6 of chapter 176J of the General Laws, as appearing in section 29 of chapter 288 of the acts of 2011, is hereby amended by adding the following paragraph:-

In addition to the projected administrative expenses and financial information, a carrier shall file information to demonstrate that the recent and projected reimbursement to health care providers is consistent with section 5A of chapter 176O.

SECTION 16. Subsection (d) of said section 6 of said chapter 176J, as so appearing, is hereby amended by adding the following paragraph:-

For base rate changes filed under this section, if a carrier files a base rate change that is based on health care provider rates of reimbursement that are not consistent with the requirements of section 5A of chapter 176O, that carrier's rate, in addition to being subject to all other provisions of this chapter, shall be presumptively disapproved as excessive by the commissioner as set forth in this subsection.

SECTION 17. Chapter 176O of the General Laws is hereby amended by inserting after section 5 the following 4 sections:-

Section 5A.

(a) No carrier shall enter, renew or extend a contract or agreement with any health care provider unless the rate of reimbursement in the new, renewed or extended contract increases by an amount less than or equal to an amount established by the commissioner, in consultation with the commissioner of health care finance and policy. Not later than

July 1 of each year, the commissioner shall by regulation establish this amount, which shall apply to contracts entered into, renewed or extended on or after the following October 1. The commissioner may establish different amounts for differing categories of contracts or providers, based on the factors in subsection (b).

(b) In establishing the amount provided in subsection (a), the commissioner shall consider the following factors:

(1) the rate of increase in the gross domestic product or consumer price index for the commonwealth;

(2) the rate of increase in total medical expenses, as reported by the division of health care finance and policy under section 6 of chapter 118G;

(3) a provider's rate of reimbursement with a carrier, especially in relation to the carrier's statewide average relative price, as reported by the division of health care finance and policy under section 6 of chapter 118G, including variability in rates where providers are above, at, or below the statewide average;

(4) whether the carrier and a contracting provider or accountable care organization are transitioning from a fee-for-service contract to an alternative payment contract; and

(5) other factors, consistent with the purposes of this section, that the commissioner may prescribe by regulation.

(c) Any savings realized by the carrier from any reduction or mitigation in the growth of provider prices shall be incorporated in the premiums charged to insured health plan members.

Section 5B. No carrier shall enter or renew a contract or agreement on or after January 1, 2012 with any hospital or inpatient facility with contract provisions that require the carrier to contract with other health care facilities that may be affiliated with that hospital or inpatient facility.

Section 5C. Beginning on January 1, 2014, carriers shall reduce claims payments to contracting health care providers who do not file claims electronically. The amount of the reduction shall be equal to the cost of processing paper claim documents above the cost of processing claims electronically and shall be prominently displayed on the method of reimbursement to the health care provider. The carrier shall submit a report annually by March 1 in a format to be determined by the commissioner pursuant to regulation that demonstrates the calculation of the administrative claims payment reduction and itemizes the number of providers affected by the reduction and amount of reduction in the prior calendar year.

Section 5D. As used in this section, terms shall have the meanings assigned by section 1 of chapter 118I. To facilitate the transition to the assumption of risk by ACOs, the standardization across providers and payers of risk and other adjusters, and to ensure transparency of payer information and protection of consumers, the division shall:

(a) Monitor risk arrangements between payers and ACOs in the commonwealth and, in consultation with the coordinating council and the division of health care finance and policy, establish any benchmarks necessary or appropriate to facilitate the transition of health care providers into integrated care delivery systems that accept risk.

(b) Solicit the expert advice of actuaries and other risk adjustment professionals and, in consultation with the coordinating council, develop methodologies for risk adjustments, risk corridors, outliers, and reinsurance to protect ACOs from assuming excess risk and the development of any such risk adjustment methodology shall include, but not be limited to, the factors set forth in subsection (j).

(c) Require by regulation that all payers maintain for all members a current roster of providers and ACOs available under the member's health benefit plan, and submit such rosters to the division. All payers shall maintain their own websites and shall post such rosters on their websites and update them at least monthly.

(d) Establish a nonprofit entity to be known as the Massachusetts ACO Reinsurance Plan, in this subsection called the plan, as follows:

(1) All ACOs shall be members of the plan. The plan shall be prepared and administered by a governing committee, appointed by the commissioner, consisting of 7 members representing ACOs participating in the plan. The governing committee shall hire employees or contractors to administer the plan.

(2) The governing committee shall submit to the commissioner a plan of operation and the commissioner shall, after notice and hearing, approve or disapprove the

plan of operation, as well as the levels of reinsurance offered and levels of premiums charged to ACO members for reinsurance. Subsequent amendments to the plan shall be considered approved by the commissioner if not expressly disapproved in writing by the commissioner within 30 days from the date of filing.

(3) The plan shall not reimburse an ACO with respect to the claims of a reinsured patient covered under the ACO's contract in any calendar year until the ACO has paid benefits in a calendar year for services otherwise covered by its contract.

(4) Meetings of the governing committee of the plan shall be conducted in accordance with the provisions of sections 18 to 25, inclusive, of chapter 30A.

(5) Following the close of each fiscal year, the governing committee shall determine for the next fiscal year, the premiums to be charged for reinsurance coverage, the reinsurance plan expenses for administration, and the incurred losses, if any, for the prior year, taking into account investment income and other appropriate gains and losses, subject to the approval of the commissioner.

(6) Any net loss for the year shall be recouped by assessment of members. This assessment shall be determined in proportion to the members' respective share of total reimbursement from ACO contracts received in the prior year. The assessment charged any ACO shall not exceed 5 percent of total reimbursement from ACO contracts received in the prior year. If the assessment level is inadequate, the governing committee may adjust the reinsurance thresholds, retention levels or consider other forms of reinsurance. (7) The governing committee shall report annually to the commissioner and the joint committee on financial services about its financial experience, the effect of reinsurance on the

number of patients ceded and recommendations, if any, on additional funding sources, if needed.

(8) If other funding sources are not made available, the committee may enter into negotiations with plan members to resolve any deficit through reductions in future payment levels. Any such recommendations shall take into account the findings of an actuarial study to be undertaken within the first 3 years of the plan's operation to evaluate and measure the relative risks being assumed by ACOs. The study shall be conducted by three actuaries appointed by the commissioner, two of whom shall represent reinsuring ACOs and one of whom shall represent the commissioner.

(e) Commencing January 1, 2014, in consultation with the coordinating council and the division of health care finance and policy, if the division determines that risk and other adjustments are not adequately standardized and consistent across all payers in the commonwealth and that such standardization and consistency are necessary for containing costs and improving the quality of and maintaining access to care, establish by regulation appropriate standard risk adjusters which shall be utilized by all payers in the calculation of rates of payment resulting from the implementation of alternative payment methods. These standard risk adjusters shall include, but not be limited to, accommodation of the following factors:

1. Cost experience and efficiencies;

2. Acuity of patient case mix;

3. Clinical health status and probability of illness;

4. Socioeconomic case mix;

5. Geographic location;

6. Cultural and linguistic diversity in patient mix; and

7. Volume of underserved low-income patients.

(f) Adopt measures to ensure that its activities with respect to regulation of risk and other adjustment factors do not undermine or otherwise impede the ability of consumers to have access to an appropriate forum for the resolution of any grievances relating to care received through an ACO. This section does not authorize the division to regulate the Medicaid program, but the Medicaid program shall implement the division's regulatory standards to the extent consistent with federal law.

(g) Have authority to adopt regulations to establish financial oversight provisions, including for reserves and other financial solvency-related requirements, that shall apply to ACOs and other health care providers that take on risk pursuant to an alternative payment contract.

(h) Submit a written report annually to the coordinating council on all risk and methodological evaluations performed, all findings from such evaluations, and regulations promulgated pursuant to its obligations and authority under this chapter; provided, that such report shall include a plan for achieving and implementing standardized risk and other adjustments with payers and purchasers in the commonwealth. The coordinating council may require the division to submit additional or supplemental reports or analyses.

(i) Participate in all meetings of the coordinating council, and participate in making recommendations to other agencies represented on the coordinating council to promote the goals and purposes of this section.

(j) Adopt or otherwise implement all recommendations made by the coordinating council to the division.

SECTION 18. The division of insurance, in consultation with the division of health care finance and policy, shall conduct a study of the effects of section 5A of chapter 176O of the General Laws. The study shall include, but not be limited to, an examination of the impact on carrier provider networks, network adequacy, rates paid to non-participating providers, and the overall impact on carrier member premiums. The division shall file a report, with its findings and any recommendations for legislation, with the coordinating council established by chapter 118I of the General Laws and with the clerks of the senate and house of representatives not later than January 1, 2014.

Clinician-Patient Communication and Grievance Resolution

SECTION 19. Chapter 231 of the General Laws is hereby amended by inserting after section 60K the following section:-

Section 60L. (a). Except as provided in this section, a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section

60B unless the person has given the health care provider written notice under this section of not less than 180 days before the action is commenced.

(b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim.

(c) The 180 day notice period in subsection (a) is shortened to 90 days if all of the following conditions exist:

(1) The claimant has previously filed the 180-day notice required in subsection (a) against another health care provider involved in the claim.

(2) The 180-day notice period has expired as to the health care providers described in clause (1).

(3) The claimant has filed a complaint and commenced an action alleging medical malpractice against one or more of the health care providers described in clause (1).

(4) The claimant did not identify and could not have reasonably have identified a health care provider to which notice must be sent under subsection (a) as a potential party to the action before filing the complaint.

(d) The notice given to a health care provider under this section shall contain a statement of at least all of the following:

(1) The factual basis for the claim.

(2) The applicable standard of care alleged by the claimant.

(3) The manner in which it is claimed that the applicable standard of care was breached by the health care provider.

(4) The alleged action that should have been taken to achieve compliance with the alleged standard of care.

(5) The manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice.

(6) The names of all health care providers the claimant is notifying under this section in relation to the claim.

(e) Not later than 30 days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control, and shall furnish release for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection does not restrict a health care provider receiving notice under this section from communicating with other health care providers and acquiring medical records as permitted under any other provision of law. This subsection does not restrict a patient's right of access to the patient's medical records under any other law.

(f) Within 90 days after receipt of notice under this section, the health care provider against whom the claim is made shall furnish to the claimant or his or her authorized representative a written response that contains a statement of each of the following:

(1) The factual basis for the defense to the claim.

(2) The standard of care that the health care provider claims to be applicable to the action and that the health care provider complied with that standard.

(3) The manner in which it is claimed by the health care provider that there was compliance with the applicable standard of care.

(4) The manner in which the health care provider contends that the alleged negligence of the health care provider was not the proximate cause of the claimant's alleged injury or alleged damage.

(g) Within 90 days after receipt of notice under this section, the health care provider against whom the claim is made shall furnish the claimant all medical records and other documents related to the claim that are in the provider's control.

(h) If the claimant does not receive the written response required under subsection (f) within the required 90-day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 90-day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claims within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider.

(j) If the claimant does not have knowledge or notice of his injury and could not reasonably have determined the existence of injury until a time in which compliance with this section would render a claim based on such injury barred by the statute of limitations,

then the statute of limitations shall be tolled for a sufficient amount of time to allow for compliance with this section before commencing an action against a health care provider.

Treatment of Provider Apology in Litigation

SECTION 20. Chapter 233 of the General Laws is hereby amended by inserting after section 79K the following section:-

Section 79L. (a) As used in this section, the following terms shall have the following meaning:

"Health care provider", any of the following heath care professionals licensed pursuant to chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist and a mental health counselor. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such facilities.

"Unanticipated outcome" means the outcome of a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical treatment or procedure.

(b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding and shall not constitute an admission of liability or an admission against interest.

Duties of the Executive Office of Health and Human Services

SECTION 21. As used in this section, terms shall have the meanings assigned by section 1 of chapter 118I of the General Laws. To promote the adoption of alternative payment methodologies and contracting with ACOs by both private and public purchasers of health care, the executive office of health and human services shall:

(a) Seek to obtain a federal waiver of statutory provisions necessary to permit Medicare to participate in the commonwealth's alternative payment methods. Upon obtaining federal approval for Medicare participation, such participation shall be commenced

and continued and the executive office shall seek extensions or additional approvals, as necessary.

(b) By August 15, 2011, request and seek to obtain from the federal office of the inspector general by the following:

1) a waiver of the provisions of, or expansion of the "safe harbors" to, 42 U.S.C. section 1320a-7b and implementing regulations or any other necessary authorization the coordinating council determines may be necessary to permit certain shared risk and other risk sharing arrangements among providers and ACOs; and

2) a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to (e) and implementing regulations or other necessary authorization the coordinating council determines may be necessary to permit physician referrals to other providers as needed to support the transition to and implementation of global and alternative payment systems and formation of ACOs.

(c) Facilitate coordination of the use of alternative payment methodologies and contracting with ACOs across all state entities. The executive office of health and human services shall take the lead in negotiations with the Centers for Medicare and Medicaid services in contracts for reimbursement for Medicare services under this chapter.

(d) (1) Develop a pilot program with one or more health systems that are early adopters of the ACO model under chapter 118I of the General Laws, provided it determines that doing so will not conflict with other pilot programs it may be pursuing or engaged in. The pilot program shall provide quality improvement incentive grants to selected health

systems which establish and participate in a cooperative effort between representatives of employees and management that is focused on controlling costs and improving the quality of care. These piloted labor-management partnership efforts shall implement an employee education/training program and other needed initiatives in order to achieve the following goals:

(i) Engage the health systems' workforce in efforts to implement the necessary system reforms needed to move from a fee-for-service to a global payments model;

(ii) Engage the health systems' workforce in efforts to measurably improve the quality of care provided by the health system, to reduce medical errors and to decrease unnecessary health care utilization; and

(iii) Engage the health system's workforce in efforts to prepare the health system to comply with all MassHealth pay-for-performance standards and new MassHealth policies on non-payment for certain identified serious reportable events; and

(iv) Develop team-based care delivery systems that integrate the work of management, physicians and the entire health care workforce to address systemic issues and implement innovative solutions designed to reduce costs and improve the quality of care delivery.

(2) Upon completion of the pilot grant program described in paragraph (1), the executive office shall prepare a comprehensive report on the pilot program which offers legislative, regulatory and other recommendations to establish new and permanent labor-management quality incentive payment initiatives. This report shall include recommendations whether to:

(i) Create a new and permanent MassHealth quality improvement incentive payment system to promote cooperative labor-management efforts; and

(ii) Expand the new MassHealth incentive payment system to all health systems; and

(iii) Develop additional quality incentive payment systems through modifications of private insurance carriers' provider reimbursement payment methods that are designed to incentivize cooperative labor-management efforts.

(3) The executive office shall seek federal and other financial support to supplement state resources to carry out this clause (d).

(4) The executive office shall adopt regulations or procedures to carry out this clause (d).

(e) Submit a written report annually to the coordinating council on all of its waiver, coordination and negotiation obligations, and regulations promulgated pursuant to its obligations and authority under this chapter. This report shall include a plan for achieving all milestones and benchmarks relating to the transition to the ACO model of care and adoption of alternative payment methodologies by purchasers, payers, and providers of publicly funded services. The executive office shall submit additional or supplemental reports or analyses at the request of the coordinating council.

(f) Participate in all meetings of the coordinating council, and shall participate in making recommendations to other agencies represented on the coordinating council as needed to promote the goals and purposes of this act. The secretary of health and human services shall adopt or otherwise implement all recommendations made by the coordinating council to the executive office of health and human services to the extent consistent with federal law.

Behavioral Health Care Task Force

SECTION 22. There shall be a task force comprised of 9 representatives with expertise in behavioral health treatment, service delivery, integration of behavioral health with primary care, and behavioral health reimbursement systems. The coordinating council shall appoint the members of the task force. The task force shall report to the coordinating council its findings and recommendations relative to (a) the most effective and appropriate approach to including behavioral health services in the array of services provided by ACOs; (b) how current prevailing reimbursement methods and covered behavioral health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral health outcomes; and (c) the extent to which and how payment for behavioral health services should be included under alternative payment methods established or regulated under this act. The first meeting shall be convened within 60 days after passage of this act. The task force shall submit its report of findings and recommendations to the coordinating council no later than April 1, 2013.